DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

#2 revised to remove tel# POC from Lic form

PRINTED: 08/18/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
acceptable	44A122	A. BUILDING _____ B. WING _____	C 08/13/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PAVILION, THE CPC	1406 MEDICAL CENTER DRIVE LEBANON, TN 37087

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F 000	INITIAL COMMENTS Complaint Investigation numbers TN26227, TN26226, TN26225, and TN25939, were conducted August 9 to August 13, 2010, with a deficiency cited related to TN26227, TN26225, and TN25939. Refer to F-323.	F 000		
F 323 SS=G	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on record review, observations, and interview the facility failed to provide supervision and assistive devices needed to prevent accidents for four (#1, #2, #5, and #8) of eleven residents resulting in harm to residents #1 and #2 who substained injuries from falls. The findings included: Resident #1 is a current resident who was admitted to the facility on May 14, 2009, with diagnoses including Dementia, Osteoporosis, Organic Brain Syndrome, and Arteriosclerosis. Review of the Minimum Data Set (MDS) dated February 23, 2010, revealed the resident was severely impaired cognitively with short and long term memory loss and required extensive	F 323	1. For Resident #1 the Certified Nursing Assistant that left the safety belt unsecured on 3/28/2010 at 6:20 pm received verbal counseling and retraining on "Resident Safety and Following Resident's Plan of Care" on 3/28/10 by the RN Supervisor. On 5/13/2010 at 8:00 am a Certified Nursing Assistant left the seat belt unfastened when she left the resident to respond to another patient's alarm that was sounding. She received counseling and re-training on that date on the importance of ensuring the safety of the patient first and following the plan of care before responding to another alarm or any type of emergency. This counseling/in-service was performed by the Director of Nursing on 5/13/10. On 5/20/10 all staff received mandatory in-service training on fall prevention and proper operation of patient alarms. This in-service was conducted by the Staff Development Coordinator.	9/1/2010

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Rebecca Gay Lane | TITLE: Administrator | (X6) DATE: 8/30/2010

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 323	Continued From page 1 assistance to transfer. Review of the Fall Risk Assessment dated February 1, 2010, revealed the resident was scored at "10" (10 or higher is a high risk for falls). Review of the Comprehensive Care Plan dated March 12, 2010, revealed the resident had a problem/need identified related to "Risk for injuries" and the intervention was, "Safety belt with alarm while in wheelchair". Review of a Nurse's Note dated March 28, 2010, at 6:20 p.m., revealed the resident "tumbled out of chair to floor in common area". Review of the Comprehensive Care Plan revealed an intervention dated March 28, 2010, which stated, "Ensure Seat Belt used when resident unsupervised". Review of a Nurse's Note dated May 13, 2010, at 8:00 a.m., stated, "Called to resident's room...observed resident lying in floor in front of wheelchair..." Review of a Nurse's Note dated May 13, 2010, at 8:00 a.m. revealed the resident was transported by ambulance to a local hospital on May 13, 2010. Review of the hospital discharge summary dated May 14, 2010, revealed the resident was admitted to the hospital on May 13, 2010, for a fractured left femoral neck, and had a Hemiarthroplasty of the left hip on May 14, 2010. Medical record review revealed the resident was readmitted to the facility on May 14, 2010. Observation of resident #1 on August 9, 2010, at 1:00 p.m., revealed the resident in a wheelchair, in the dining area, with a seat belt and alarm in	F 323	For Resident #2 the Certified Nursing Assistant was responding to a tornado warning and was pushing resident #2 to the designated safe area. The resident usually propels self in wheelchair with her feet and is capable of lifting her feet independently. She was pushed approximately 58 ft when she abruptly put her feet down on the carpeted floor causing her to fall forward. The investigation revealed the Certified Nursing Assistant had not applied the foot pedals to the wheelchair prior to responding to the tornado warning. The Certified Nursing Assistant was suspended pending further investigation and was instructed to see the Director of Nursing on Monday 5/3/10. Subsequent phone calls and letters requesting an investigative meeting were unanswered and employee was subsequently terminated. On 5/3/10 staff was trained on Wheelchair Safety & Emergency Response. This was performed by the Staff Development Coordinator.	

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F 323	Continued From page 2 place. Observation of the resident's room on August 9, 2010, at 1:15 p.m., revealed a low bed with bolsters and padding on the floor at each side of the bed. Interview with Registered Nurse (RN) #1 in the facility's conference room on August 10, 2010, at 1:00 p.m., revealed RN #1 was at the nurse's station on March 28, 2010, between 6:00 p.m. and 7:00 p.m., when RN #1 heard a "thud" and saw Resident #1 had fallen out of...wheelchair onto the floor. RN #1 stated the resident's seatbelt and alarm were not on the resident. Interview with Certified Nursing Assistant (CNA) #1 in the facility's conference room on August 9, 2010, at 11:30 a.m., revealed the CNA transferred Resident #1 to the wheelchair on May 13, 2010, and did not attach the seat belt and alarm before leaving the resident unattended. Continued interview at this time revealed the resident was lying on the floor when the CNA returned. Interview with the Director of Nurses (DON) in the facility conference room on August 9, 2010, at 1:15 p.m., confirmed resident #1 was care planned for a seat belt with alarm when up in a wheelchair. Further interview with the DON at this time confirmed the seat belt and alarm were not on resident #1 when the resident fell on March 28 and May 13, 2010, and sustained a fracture of the left femoral neck. C/O# TN25939 and TN26227 Resident #2 is a current resident who was	F 323	Resident #5 batteries in the alarm were not functioning. On 5/29/10 staff was instructed to check alarm batteries every two hours to ensure proper functioning. This protocol was improved on 6/16/2010 to include documentation that the devices and batteries were checked and functional by the Certified Nursing Assistants every 2 hours on a log sheet. Log sheets are then checked by the charge nurse for completeness and turned into the Staff Development Coordinator for review. Resident #8 was, at his request, provided privacy while on the toilet. The Certified Nursing Assistant was at the door only a few steps away, however was unable to reach him in time to prevent the fall. Immediate retraining was done with the individual staff member regarding meeting the safety needs of the patient. This re-training was conducted by the Charge Nurse on duty.	

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F 323	Continued From page 3 admitted to the facility on March 16, 2010, with diagnoses including Parkinson's Disease and Dementia. Review of the Minimum Data Set (MDS) dated March 23, 2010, revealed the resident required partial support during the standing and sitting balance tests, and also required extensive assistance of one person to transfer or ambulate. Review of the Resident Assessment Profile (RAP) dated March 24, 2010, revealed the resident was "at risk for falls secondary to decreased mobility and functioning..." Review of a nurse's note dated May 1, 2010, at 4:00 pm, revealed Resident #2 was "... in floor face down in hallway...with a large skin tear to right forehead..." Further review of the nurse's notes revealed the resident was transferred to a local hospital by ambulance on May 1, 2010, at 4:15 p.m. and returned to the facility at 11:30 p.m. the same day. Review of a hospital discharge summary dated May 15, 2010, revealed the resident was admitted to a second hospital on May 6, 2010, for treatment of injuries substained during the fall on May 1, 2010, and was diagnosed with a Ruptured Globe of the Left Orbit. Further review of the discharge summary revealed the resident had surgical repair of a Corneal Scleral Laceration on May 7, 2010. Review of the resident's Admission Face Sheet and a Nursing Admission Assessment dated May 31, 2010, revealed the resident returned to the facility on May 31, 2010. Observations of Resident #2 in the resident's room on August 9, 2010, at 3:30 p.m., revealed the resident was alert and oriented to person, place and time. Interview with the resident, in the	F 323	2. To assist in identifying other residents have the potential for the same problems we completed on 5/14/2010 the following: (a) 100% audits of fall risk assessments for completion; (b) 100% audit of care plan interventions for every parameter of the fall risk that has a score of 2-4; (c) 100% audit of the communication sheet to ensure care plan interventions were followed through on the CNT communication sheet. The audits were completed by nursing administration staff including the Director of Nursing, Staff Development Coordinator and MDS nurse. These areas will continue to be monitored using an Excel tool from Q-Source and will be presented at monthly Quality Assurance meetings. If patterns or trends are detected, additional audits will be completed by the DON or her designee. A 100% audit of falls was completed by the RN consultant from Q-source on 8/17,8/25, 8/26 and 8/27. Recommendations were reviewed and implemented by the Director of Nursing &/or her designees.	

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F 323	Continued From page 4 resident's room, on August 9, 2010, at 3:30 p.m., revealed the resident remembered being transported by wheelchair during a tornado warning and stated, "something happened and threw me into the floor". Interview with Visitor #1 by telephone on August 11, 2010, at 3:00 pm, revealed this visitor had witnessed Resident #2's fall on May 1, 2010. Visitor #1 stated there had been a "tornado warning" on May 1, 2010, and staff were moving all residents to safe areas. Visitor #1 also stated, "the nurse tech was pushing a patient, she was in a wheelchair, and put...feet down on floor, and it threw her forward out of wheelchair onto floor." Interview with RN #1 in the facility's conference room on August 10, 2010, at 1:00 p.m., revealed RN #1 investigated resident #2's fall immediately after it occurred on May 1, 2010. RN #1 stated , "I did not see the incident, I was on the 100-200 wing and when I went over there...was face down on floor". Further interview with RN #1 at this time revealed,"I dont think the foot pedals were on the wheelchair...the resident's feet were not on the foot pedals. The resident set...feet down and went over forward". Interview with the Physical Therapist (PT) by telephone on August 13, 2010, at 1:30 p.m., revealed it is not considered a safe practice to transport a resident by wheelchair without using the feet pedals, unless the resident can hold their feet up independently. Further interview with the PT revealed it would be safe to transport a resident no more than 200 feet without using the foot pedals, if the resident was able to lift their feet independently.	F 323	On 8/10/2010 the Administrator reviewed staffing for each day a fall occurred to ensure nursing hours per patient day were sufficient to meet the needs of our residents. Nursing Hours Per Patient Day ranged from 2.78 to 5.21 and was deemed not a contributing factor. Staffing hours is continued to be reviewed on a daily basis by the Director of Nursing and Administrator. *Daily,* Certified Nursing Technicians are responsible for checking safety devices every two hours and document on the log sheet. Charge nurses are required to check behind staff at least once and sign off on the log sheet. The Inter-disciplinary team has been provided with a list of patients with safety devices and completes random checks of these devices. Any problem is immediate corrected and then reviewed during daily stand-up meetings. All incident reports are reviewed by the Inter-disciplinary team during morning stand-up meetings to ascertain appropriate interventions are in place. The inter-disciplinary team consists of administrator, the director of nursing, the staffing coordinator, the MDS Nurse, the Social Service Director, Activities Director, Dietary Manager, Business Office Manager, Housekeeping/Laundry Supervisor and weekend RN Supervisor.	

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F 323	Continued From page 5 Interview with the DON in the facility's conference room on August 9, 2010, at 1:15 p.m., confirmed the CNA had not used the wheelchair's foot pedals to support the resident's feet while transporting resident #2 on May 1, 2010. Continued interview with the DON at this time confirmed the resident had fallen from the wheelchair on May 1, 2010, and sustained a ruptured globe of the left orbit. C/O# TN26225 Resident #5 was admitted to the facility on May 18, 2010, with diagnoses to include Dementia with Delirium, Syncope, Depressive Disorder, Osteoporosis, Hypertension, and Degenerative Joint Disease. Medical record review of the Minimum Data Set, dated May 25, 2010, revealed the resident had short and long term memory deficits; moderately impaired decision making skills; and required one person assistance with transfers, bed mobility, and ambulation. Medical record review of the Fall Risk Assessment dated May 18, 2010, revealed the patient scored an 18 (10 or greater = high risk). Medical record review of the Care Plan dated May 18, 2010, revealed the resident had been identified at high risk for falls with interventions to prevent falls to include "...pad alarm to bed (implemented May 22, 2010)...pad alarm to wheelchair...check alarms and batteries every two hours to assure proper functioning (implemented May 29, 2010)..." Medical record review of the Nurse's Note dated May 29, 2010, at 9:30 p.m., revealed "...called to room by CNA (Certified Nursing Assistant)...Lying on floor on back in front of recliner...no injury..."	F 323	*Weekly*, during "At Risk Meeting", patients who have been identified at risk for falls are reviewed by the Interdisciplinary Team, evaluated and patterns reviewed. The Interdisciplinary Team consists of the Administrator, the Director of Nursing, Staffing Coordinator, MDS Nurse, Social Services, Activities Director, Dietary Manager and Rehab Director. *Monthly*, during Quality Assurance meetings falls are reviewed for any trends or patterns including time of day, shift, location, restraints, and type of fall, injury or no injury. Additionally, falls are mapped on a facility floor plan showing the location of the falls and reviewed with the CNT's responsible for each wing by the Director of Nursing and Staff Development Coordinator. Members of the Quality Assurance Committee include, the Medical Director, the Administrator, the Director of Nursing, the Pharmacy Consultant, a guest Physician, Social service Director, Activities Director, Dietary manager, Housekeeping and Laundry Supervisor.	

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F 323	Continued From page 6 Review of the facility investigation dated May 29, 2010, revealed "...resident alarm not working properly (had to replace batteries)...replaced batteries...check alarm and battery every two hours..." Interview in the conference room with the DON (Director of Nursing) on August 13, 2010, at 3:00 p.m., revealed the resident was curently an inpatient in a geriatric psychiatric facility for medication management. Continued interview confirmed the safety device to prevent falls had not been functioning properly at the time of the fall. Resident #8, a closed record review, was admitted to the facility on March 17, 2010, with diagnoses to include Lung Cancer with Metastases to the Brain, Hypertension, and Vertigo. Medical record review of the Fall Risk Assessment dated March 17, 2010, revealed the resident scored 10 (10 or greater = high risk). Medical record review of the Care Plan dated March 17, 2010, revealed the resident had been identified to be at high risk for falls with interventions to prevent falls to include "...encourage to ask for assistance...call light in reach... proper foot wear...total care with transfers...tab alarm to wheel-chair and bed (implemented April 1, 2010)...BSC (Bed Side Commode)(implemented April 24, 2010)..." Medical record review of the Minimum Data Set dated March 24, 2010, revealed the resident had no problems with short or long term memory; had some difficulty in new situations; required one person assistance with bed mobility; required two	F 323	3. Measures taken to ensure these types of incident do not reoccur include: (a) We have enhanced CNT training to include a skills competency checklist as a method of documenting competency of the Certified Nursing Assistant in all areas to include, but not limited to: use of restraints, lifting devices, transfer and safety techniques all of which aid in fall prevention. The staff development coordinator completed these checklists on July 9, 2010 on all current CNT's and will also be responsible to complete the skills competency checklist with all new hires of CNT during orientation and a repeat skills competency with all CNT's on an annual basis. Every CNT must be able to recite or perform proper procedure. Re-training will occur for any weaknesses. Disciplinary action, up to and including termination, will occur to any CNT unable to pass the skills competency testing after unsuccessful retraining.	

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F 323	Continued From page 7 person assistance with transfers; was non-ambulatory during the prior seven days; and the test of sitting and standing balance could not be performed without physical help. Medical record review of the Nurse's Note dated April 24, 2010, at 10:00 a.m., revealed "...called to room by CNA...Resident on floor beside toilet in bathroom...bump to Rt (right) side of head and ST (skin tear) to left hand..." Review of the facility investigation, dated April 24, 2010, revealed "...CNA tried to provide privacy and stood at door...witnessed (resident) begin to fall and could not reach (resident) in time...CNA wasn't aware resident could not sit on toilet without someone present...BSC in future..." Interview in the conference room with the DON on August 13, 2010, at 3:00 p.m., confirmed the resident had been left unattended in the bathroom on April 24, 2010, and the resident sustained a fall from the commode.	F 323	(b) On 8/6/2010 we partnered with Q-Source in a collaborative to reduce restraints and decrease falls and will be utilizing their Ex-cel tracking tool as a method of tracking and trending information about falls. On 8/25/10 and 8/26/10 the RN consultant from Q-source conducted a records review and completed training with the Director of Nursing, Staff Development Coordinator and MDS Nurse on proper documentation and made recommendations for improvement. She also completed a training on Fall Management with staff on 8/27/10 and provided materials to the Staff Development Coordinator to use with any staff member unable to attend the in-service on that day. This training will be completed by 8/30/10 for all regular staff members and prior to return to work for any PRN staff members. (a) Licensed staff received training on 6/7/10 on "The Importance of Implementing Immediate	

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F 323		F 323	Interventions After a Fall Occurrence and provided a tool delineating various types of interventions that can be implemented immediately. The training was completed by the DON. A copy of the tool has been added to the communication book for easy reference for the staff. Follow up rounds are made by the DON and/or her designees to ensure interventions are in place on a daily basis. (a) In-service of all current employees was held on 5/20/2010 on Fall Prevention. Those not present received one on one training by the staff development coordinator. This is addressed during orientation of each new employee. (b)RN Consultant from Q-Source provided a mandatory in-service on Fall Management on 8/27/10 to all staff . The Staff Development Coordinator will be responsible to complete training by 8/30/10 for regular staff members and prior to returning to work for any PRN staff members. © In the future any resident requesting privacy during toileting will be educated on the risk factors of being left unsupervised while toileting. Resident will be encouraged to allow staff to assist during this ADL. Physical Therapy will screen for alternative safety measures to promote independence, safety and desired privacy levels as	

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F 323		F 323	appropriate. If resident continues to refuse, the refusal will be care planned acknowledging resident's rights to refuse treatment . 4. Corrective Actions will continue to be monitored by the Quality Assurance Meeting on a monthly basis for trending and analysis. A list of safety devices have been provided to the Inter-disciplinary team which includes the Administrator, Director of Nursing, Staff Development Coordinator, MDS Nurse, Social Service Director, Activities Director, Dietary Manager and Housekeeping Supervisor. The Staff Development Coordinator made initial rounds with these members and demonstrated how to assure that the safety devices were in place, functional, and being utilized correctly. The Inter-disciplinary Team will randomly conduct spot checks and provide extra support to staff so that the devices are in place and functioning correctly.	

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F 323		F 323	To reduce fall risks we will continue to complete falls assessments upon admission, quarterly , and with significant change in condition. Individualized care plans are evaluated and modified after each assessment or fall and will include evaluations of medications, medical status, and behaviors with individualized interventions implemented. OT/PT evaluations will be conducted for gait and balance training, "safe strides" programming, as well as evaluation of equipment and posturing devices. Increased activity and exercise programs have been added to compliment our restorative program. The Director of Nursing and/or her designees are responsible to monitor CNT training, fall prevention, safety devise use, and investigate all falls with appropriate interventions through review of records, direct observation and review of all falls on a daily basis.	

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